STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA ((X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		155761	B. WING			03/03/2011		
			p		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIER	8			TILDEN			
BROWNSBURG MEADOWS		3		BROW	NSBURG, IN46112			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
F0000	This visit was for	r a Recertification and	F000	00	The creation and submission of	of		
	State Licensure S	Survey.			this Plan of Correction does no			
	~				constitute an admission by this			
	Survey dates: Fe	ebruary 28, March 1, 2 &			provider of any conclusion set forth in the statement of			
	3, 2011	20, 1,12,011, 2,00			deficiencies, or of any violation	n of		
	3, 2011				regulation.			
	Facility number:	011367						
	Provider number				This provider respectfully requests that the 2567 Plan of	.		
	AIM number: 20				Correction be considered the			
	Alivi liuliloci. 20	00831390			Letter of Credible Allegation a			
	C				requests a Desk Review in lie	u of		
	Survey team:	LTO			a Post Survey Review on or a	fter		
	Marcy Smith RN				March 28, 2011			
	Rhonda Stout RN							
		(March 1, 2 & 3, 2011)						
		farch 1, 2 & 3, 2011)						
	Diane Dierks RN	N (March 3, 2011)						
	Census bed type:	:						
	SNF/NF: 101							
	SNF: 26							
	Residential: 11							
	Total: 138							
	Census payor typ	pe:						
	Medicare: 34							
	Medicaid: 71							
	Other: 33 Total: 138							
	Sample: 24							
	Residential samp	ole: 7						
	Residentiai samp	JIC. /						
	This deficiency a	also reflects state findings						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FLJG11

Facility ID:

011367

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155761		(X2) MULTIPLE CO A. BUILDING B. WING		03/03	E SURVEY PLETED /2011
NAME OF PROVIDER OR SUPPLIER BROWNSBURG MEADOWS		2 EAST	ADDRESS, CITY, STATE, ZIP COD TILDEN NSBURG, IN46112	E	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
in accordance with Quality review con Jennie Bartelt, RN	h 410 IAC 16.2. mpleted 3/8/11 by				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		DENTIFICATION NUMBER: A. BUILDING		COMPLETED		ETED	
15		155761	B. WING			03/03/20)11
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L.			TILDEN		
BROWNSBURG MEADOWS				NSBURG, IN46112			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0502	Based on reco	rd review and	F05	02	It is the practice of this provide provide or obtain laboratory	er to	03/28/2011
SS=D	interview, the	facility failed to			services to meet the needs of	its	
	ensure laborate	ory services were			residents. The facility is		
	drawn as orde	red for 2 of 21			responsible for the quality and		
	residents revie	ewed for laboratory			timeliness of the services. W corrective action(s) will be	nat	
		•			accomplished for those		
	services in a sa	-			residents found to have beer	,	
	(Residents #91	l and #47)			affected by the deficient		
					practice? The lab was contac	ted	
	Findings include:				about Resident #91. His labs		
	i mamga mera	ide.			were re-instated by the lab. Th	ne	
					orders for Resident #47		
	1. The record	for Resident #91 was			were reviewed with the lab to make sure the correct order	.	
	reviewed on 3	/2/11 at 10:00 a.m.			were recorded in their comput		
					system. How will you identi		
	.	D 11 W01			other residents having the	, I	
	Diagnoses for	Resident #91			potential to be affected by th	е	
	included, but v	were not limited to,			same deficient practice and		
	hypertension,	diahetes			what corrective action will be	•	
					taken? The facility obtained		
	hypothyroidisi				computer access to the labs		
	gastroparesis (decreased ability to			computer system to do a hous	se	
	empty stomac	h contents related to			wide audit and compare physician's orders with the ord	lore	
	diabetes).				in the labs database to assure		
	ulabetes).				they matched. The pharmacy		
					provides the physicians rewrite		
	A recapitulated	d physician's order			also provided a current list of a	all	
	-	1, with an original			physician labs orders and thes	se	
		_			were compared as well. The		
		010, indicated the			facility also requested the work		
	resident was to	o receive a BMP			of the lab orders to be change on the rewrites to create less	u	
	(Basic Metabo	olic Panel) once a			confusion. The facility will utilize	_{ze a}	
	`	MP lab draw for			lab tracking system. The Staff		
					Development Coordinator		
	January 2011	was missing from the			completed three in-services or		
					3/16/11 and ongoing for licens	ed	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		A. BUILDING			03/03/2		
		100701	B. WIN			03/03/2	011
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
BROWNSBURG MEADOWS				1	TILDEN NSBURG, IN46112		
					1000110, 114-0112		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
1710	1	e facility was unable	+	1110	nurses with topics including a	lab	DITTE
	1	•			tracking system, writing lab		
	_	ormation about the			orders, creating lab requisition	s,	
	lab draw.				and reviewing lab orders on		
					re-writes. The facility is also researching lab company		
	During an inte	erview with the			alternatives in the area that wi		
		ector on 3/2/11 at			service long term care facilities	3.	
	l				What measures will be put into		
		e indicated the			place or what systemic change you will make to ensure that the		
	Ī	aw was because the			deficient practice does not	ic	
	lab tech came	in and saw that the			recur? The facility will utilize a	lab	
	resident was n	o longer in the room			tracking system. The Staff		
		t resident was there,			Development Coordinator		
		inician assumed			completed three in-services or 3/16/11 and ongoing for licens		
	l				nurses with topics	eu	
		had been discharged			including writing lab orders,		
	and removed t	the resident from the			creating lab requisitions, and		
	list to have blo	ood drawn. She			reviewing lab orders on re-writ		
	indicated Resi	dent #91 had been			The facility is also researching company alternatives in the ar		
	l	fferent room and the			that will service long term care		
					facilities. How the corrective		
	1	npany should have			action(s) will be monitored to		
	asked if the re	sident had been			ensure the deficient practice		
	discharged or	moved to another			will not recur, i.e., what quali	-	
	room.				assurance program will be pointo place? A CQI tool for Lal		
					Diagnostics has been initiated		
					and will be completed by the		
					Director of Nursing/Designee.		
					This tool will be completed 3 times a week x 2 weeks, week	lv x	
					4 weeks, and then monthly x 3		
					months. This CQI tool will be		
					reviewed through the Quality		
					Assurance team monthly.		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG		COMPL	ETED
		155761	A. BUII		-	03/03/2	011
			B. WIN		DDDFGG CITY GTATE TID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DD 014414					TILDEN		
BROWNSBURG MEADOWS		5		BROW	NSBURG, IN46112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG			DATE
F0502	2. The record of	Resident #47 was	F05	02	It is the practice of this provide	er to	03/28/2011
SS=D	reviewed on 3/2/	11 at 3:25 p.m.			provide or obtain laboratory services to meet the needs of	ite	
					residents. The facility is	າເວ	
	Diagnoses for Re	esident #47 included, but			responsible for the quality and		
		to, anemia, coronary			timeliness of the services. W		
		d chronic obstructive			corrective action(s) will be		
	,				accomplished for those		
	pulmonary diseas	se.			residents found to have beer	า	
					affected by the deficient		
	A physician's ord	ler dated 1/5/11 indicated			practice? The lab was contact	ted	
	Resident #47 was	s to have a CBC			about Resident #91. His labs		
	(Complete Blood	l Count) and CMP			were re-instated by the lab. Th	ne	
		Metabolic Panel) drawn			orders for Resident #47		
	` •	11. There were no results			were reviewed with the lab		
					to make sure the correct order		
		ordered for 1/6/11 in the			were recorded in their compute system. How will you identi		
	resident's record.				other residents having the	ııy	
					potential to be affected by th	_	
	Further informat	ion was requested from			same deficient practice and	C	
	the Executive Di	rector on 3/2/11 at 6:00			what corrective action will be	2	
	n m regarding re	esults for lab draws			taken? The facility obtained		
	ordered for 1/6/1				computer access to the labs		
	oracica for 1/0/1	1.			computer system to do a hous	e	
					wide audit and compare		
		30 a.m. LPN #1, Unit			physician's orders with the ord	lers	
	Manager, indicat	ted the order for the CBC			in the labs database to assure		
	and CMP for bot	h 1/6/11 and 1/13 11			they matched. The pharmacy		
	were sent on the	same requisition to the			provides the physicians rewrite		
		ed the labs on 1/13/11			also provided a current list of a physician labs orders and thes		
		he labs for 1/6/11 were			were compared as well. The	oc	
	not drawn.	110 1000 101 1/0/11 WOIL			facility also requested the work	dina	
	not urawn.				of the lab orders to be change	•	
	2.1.40(.)				on the rewrites to create less		
	3.1-49(a)				confusion. The facility will utiliz		
					lab tracking system. The Staff		
					Development Coordinator		
					completed three in-services or		
					3/16/11 and ongoing for licens	ed	
			1				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		155761	B. WING		03/03/2011
NAME OF F	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	•
TO TWILL OF T	While of TROVIDER OR SOFTELLR			T TILDEN	
	SBURG MEADOWS			/NSBURG, IN46112	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	ļ	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	nurses with topics including a tracking system, writing lab orders, creating lab orders on re-writes. The facility is also researching lab company alternatives in the area that will service long term care facilitie. What measures will be put into place or what systemic chang you will make to ensure that the deficient practice does not recur? The facility will utilize a tracking system. The Staff Development Coordinator completed three in-services of 3/16/11 and ongoing for licens nurses with topics including writing lab orders, creating lab requisitions, and reviewing lab orders on re-writhe facility is also researching company alternatives in the air that will service long term care facilities. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qualication and will be completed by the Director of Nursing/Designee. This tool will be completed 3	lab ls, ll s. les les les lab ltes. lab leea les
				times a week x 2 weeks, week 4 weeks, and then monthly x 3	· •
				months. This CQI tool will be reviewed through the Quality	
				Assurance team monthly.	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
155761		155761	B. WING			03/03/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				TILDEN		
BROWNSBURG MEADOWS				NSBURG, IN46112			
					1.020.10, 11.101.12		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION DATE
		LSC IDENTIFYING INFORMATION)	FOS		It is the practice of this provide	r to	
F0504		review and interview the	F05	J 4	provide or obtain laboratory	:1 10	03/28/2011
SS=D	<u>-</u>	ensure labwork was			services only when ordered by	,	
	completed only u	ipon physician's order for			the attending physician. What		
	1 of 21 residents	reviewed for having their			corrective action(s) will be		
	labwork done in	a sample of 24. (Resident			accomplished for those		
	#107)				residents found to have beer	ı	
	,				affected by the deficient		
	Findings include				practice? A meeting was held		
	Findings include.				with the lab to review the order	rs	
	Tl 1 . CD .	:1			of resident #107. The MD and	ho.	
	The record of Re				family was notified regarding to lab draws. How will you identi		
	reviewed on 3/1/11 at 2:00 p.m.				other residents having the	'y	
					potential to be affected by the	e	
	Diagnoses for Re	esident #107 included,			same deficient practice and		
	but were not limi	ited to, left calf deep vein			what corrective action will be	,	
	thrombosis (bloo	od clot), multiple			taken? All other residents who	0	
	sclerosis, neurop	athy and			have lab orders have the abilit		
	lymphadenopath	-			be affected. The facility obtain	ed	
	1) inpilacenopatii	<i>.</i>			computer access to the labs	_	
	A reconitulated r	ohysician's order for			computer system to do a hous wide audit and compare	е	
		· ·			physician's orders with the ord	ers	
		th an original date of			in the labs database to assure		
	*	d Resident #107 was to			they matched. The pharmacy t	that	
	,	a blood test to measure			provides the physicians rewrite		
	how fast the bloc	od clots) drawn weekly.			also provided a current list of a		
					physician labs orders and thes	e	
	Review of the res	sident's lab results for			were compared as well. The facility also requested the word	ding	
	January and Febr	ruary 2011, indicated she			of the lab orders to be change	-	
	_	awn on the following			on the rewrites to create less	~	
		10, 12, 17, 19, 24, 29 and			confusion. The facility will utilize	ze a	
		bruary 2, 7, 9, 21 and 23,			lab tracking system. The Staff		
		_			Development Coordinator		
	_	physician's orders were			completed three in-services or		
		dent's record for these			3/16/11 and ongoing for licens		
	additional lab dra	aws.			nurses with topics including a tracking system, writing lab	IaD	
					orders, creating lab requisition	s.	
					2. 25.6, 5. 52aig lab requisition	-,	

 155761		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		A. BUILDING B. WING			03/03/2		
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	{		2 EAST	TILDEN		
BROWNSBURG MEADOWS				BROW	NSBURG, IN46112		
(X4) ID		STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULE				(X5)
PREFIX TAG	·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
		ion was requested from			and reviewing lab orders on		D.III.E
		irector on 3/1/11 at 3:30			re-writes. The facility is		
	p.m. regarding v	why the additional			also researching lab company alternatives in the area that wi		
		lrawn for Resident #107.			service long term care facilities		
					What measures will be put into		
	During interview	v on 3/3/11 at 10:00 a.m.,			place or what systemic change		
	the Executive D	irector indicated the			you will make to ensure that the deficient practice does not	l C	
	reason the reside	ent had so many labs			recur? The facility will utilize a	lab	
	drawn was becar				tracking system. The Staff		
	l ^	ame to the facility to draw			Development Coordinator completed three in-services or	,	
	the labs, nurses, not knowing when the				3/16/11 and ongoing for licens		
		ıled lab draw day was,			nurses with topics		
		hey did not have the			including writing lab orders, creating lab requisitions, and		
		ident's weekly PT/INR			reviewing lab orders on re-writ	es.	
	1 -	omists would draw the			The facility is also researching	lab	
		thinking the nurse was			company alternatives in the ar		
	_	Then the lab would come			that will service long term care facilities. How the corrective		
	1	on the scheduled lab			action(s) will be monitored to		
	•	raw it again, not knowing en drawn that week. The			ensure the deficient practice		
	I	tor indicated at this time,			will not recur, i.e., what quali		
		od thing. I'm talking to			assurance program will be pointo place? A CQI tool for Lab		
	1	esentative] about this."			Diagnostics has been initiated		
	our ide rep [repr	osemunivej uoout mis.			and will be completed by the		
	3.1-49(f)(1)				Director of Nursing/Designee. This tool will be completed 3		
					times a week x 2 weeks, week	ly x	
					4 weeks, and then monthly x 3		
					months. This CQI tool will be		
					reviewed through the Quality Assurance team monthly.		